# 2011 Military Health System Conference

## TRICARE Fourth Generation Study Group – Exploring the Way Forward

*The Quadruple Aim: Working Together, Achieving Success*

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26 January 2011

T4 Study Group

# Report Documentation Page

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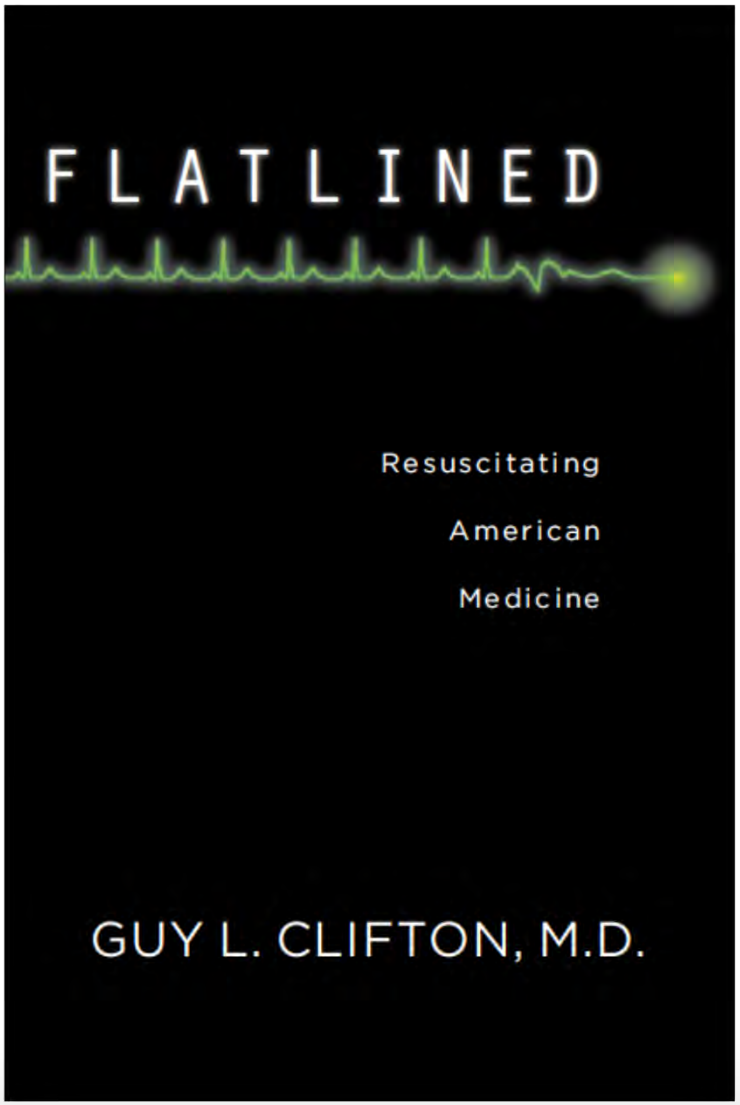

FLATLINED
Resuscitating
American
Medicine
GUY L. CLIFTON, M.D.

# Policy Environment

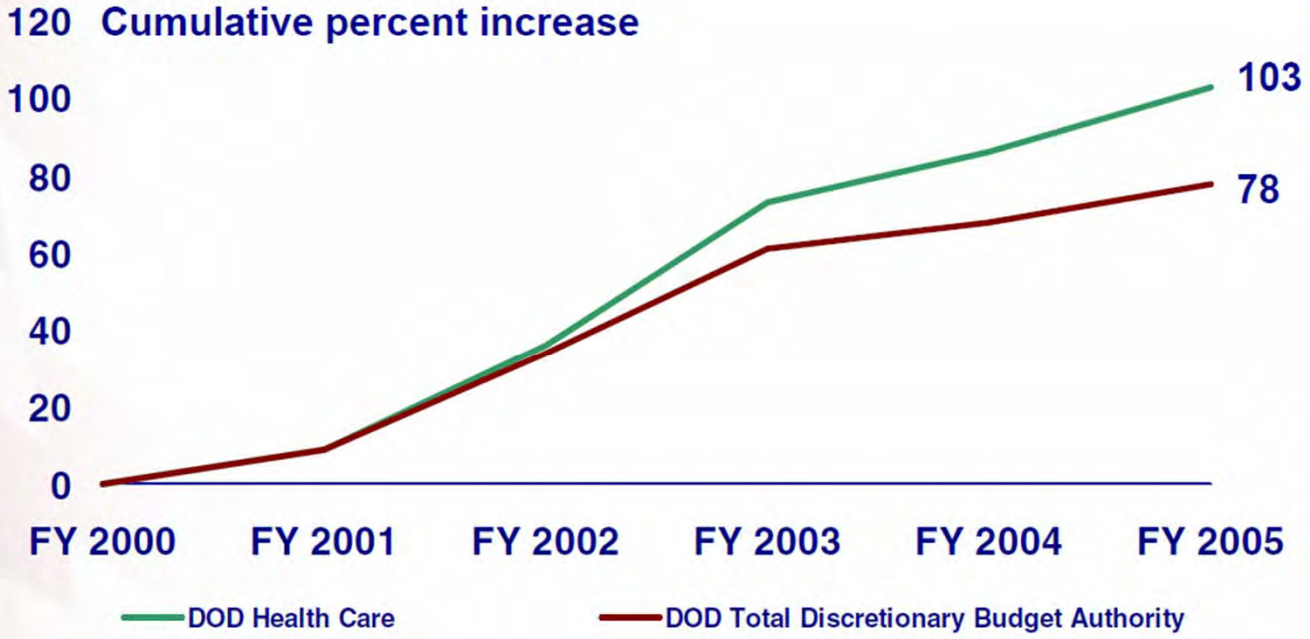
**Secretary of Defense Robert Gates has recently said health care costs are "…eating us alive,"...***

***SOURCE: Gates Criticizes Bloated Military Bureaucracy--Defense Secretary Vows Top-Down Assessment of Pentagon Budget, from Staffing to Ubiquitous "Overhead" Costs, By David Martin*

# Health Care Grows Faster than DOD Budget Authority

GAO
Accountability • Integrity • Reliability

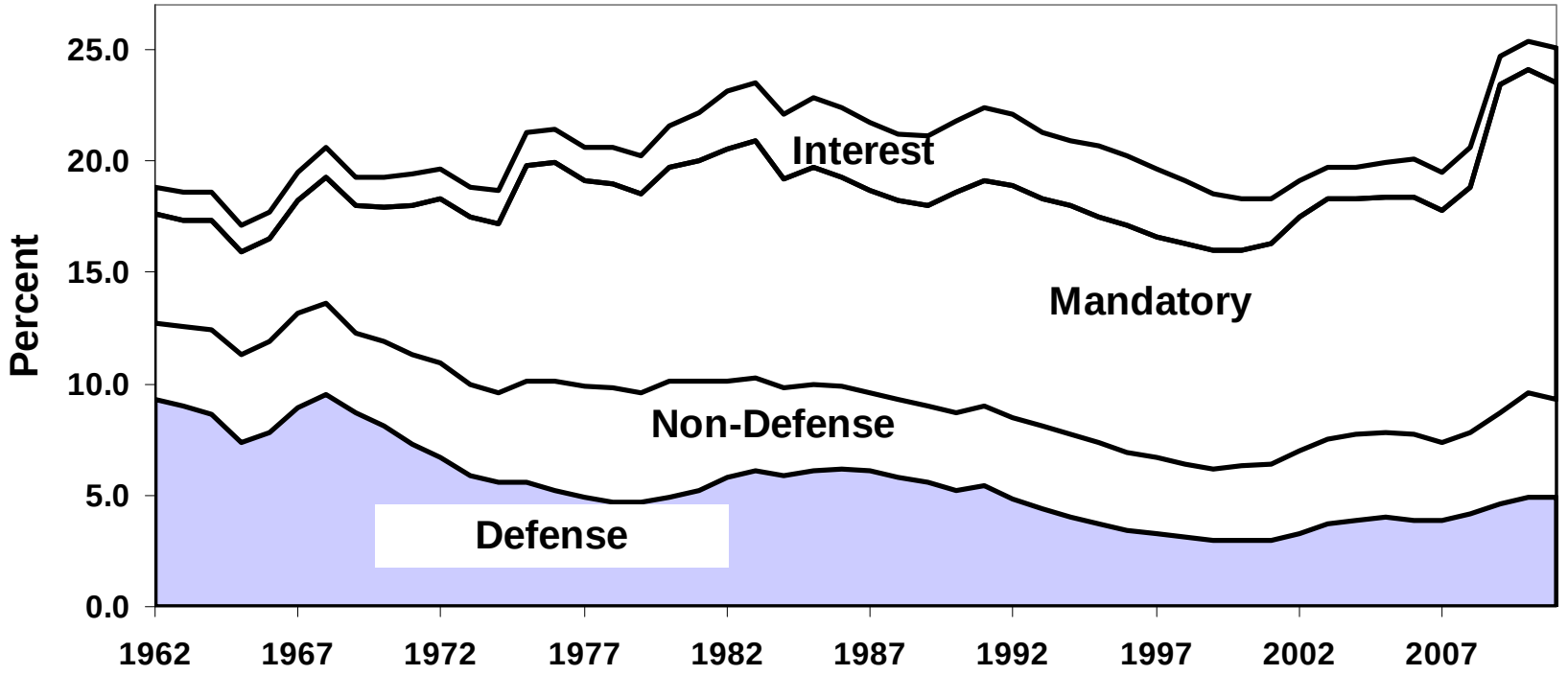
## DOD Health Care Spending has been Growing Faster than DOD's Discretionary Budget Authority




Source: GAO analysis of DOD data.

# In the Face of Record Federal Debt--- History Teaches that Defense Spending will be Cut.

## Federal Outlays
### Share of GDP

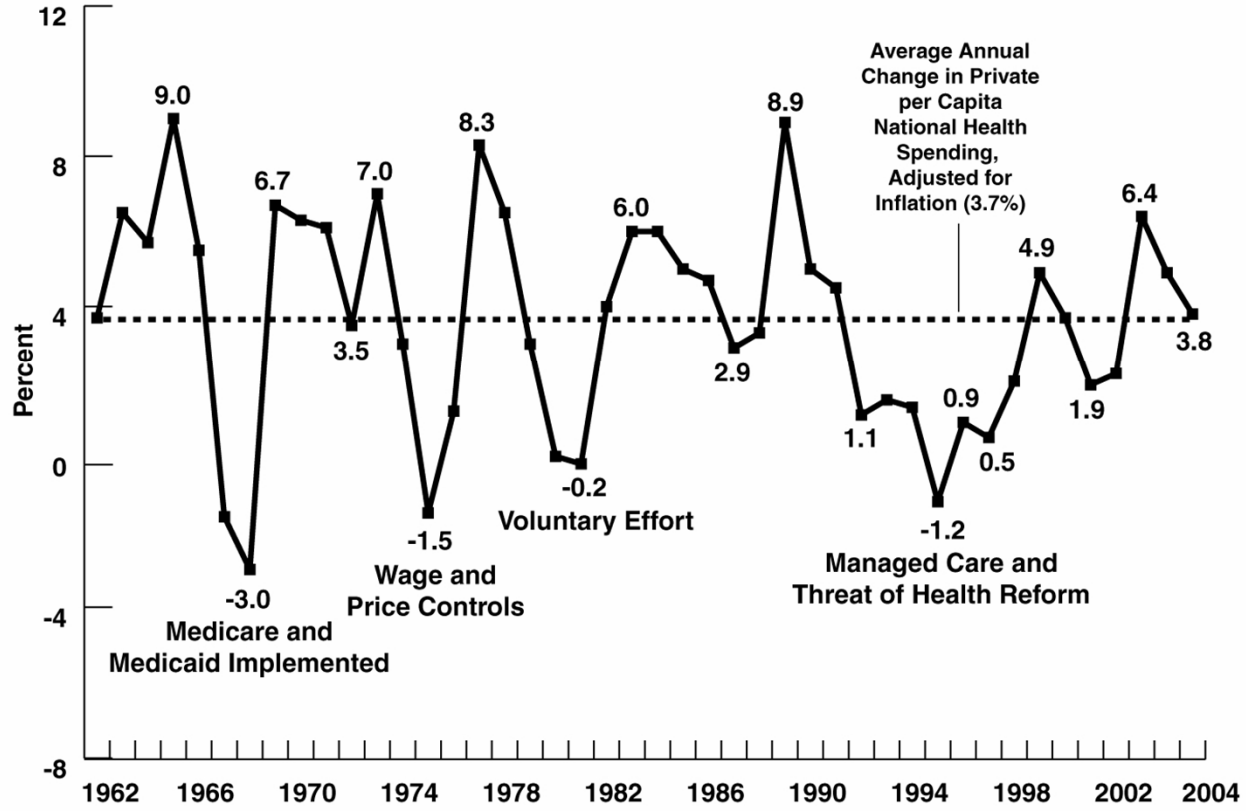



*MIT Security Studies Program, November, 2010*

# Why Should I Care?

# Price Cuts are not Effective for Long and can Destabilize Care.

**Annual Change in Private per Capita National Health Spending (Adjusted for Inflation), with Historical Health Spending Events, 1960-2004**




*Source: Trends and Indicators in the Changing Health Care Marketplace. Exhibit 1.4. Publication 7031. Health Care Marketplace Project. Kaiser Family Foundation. May 2005.*

# The Way Forward

**Will Providers Accept Accountability for Cost and Quality?**

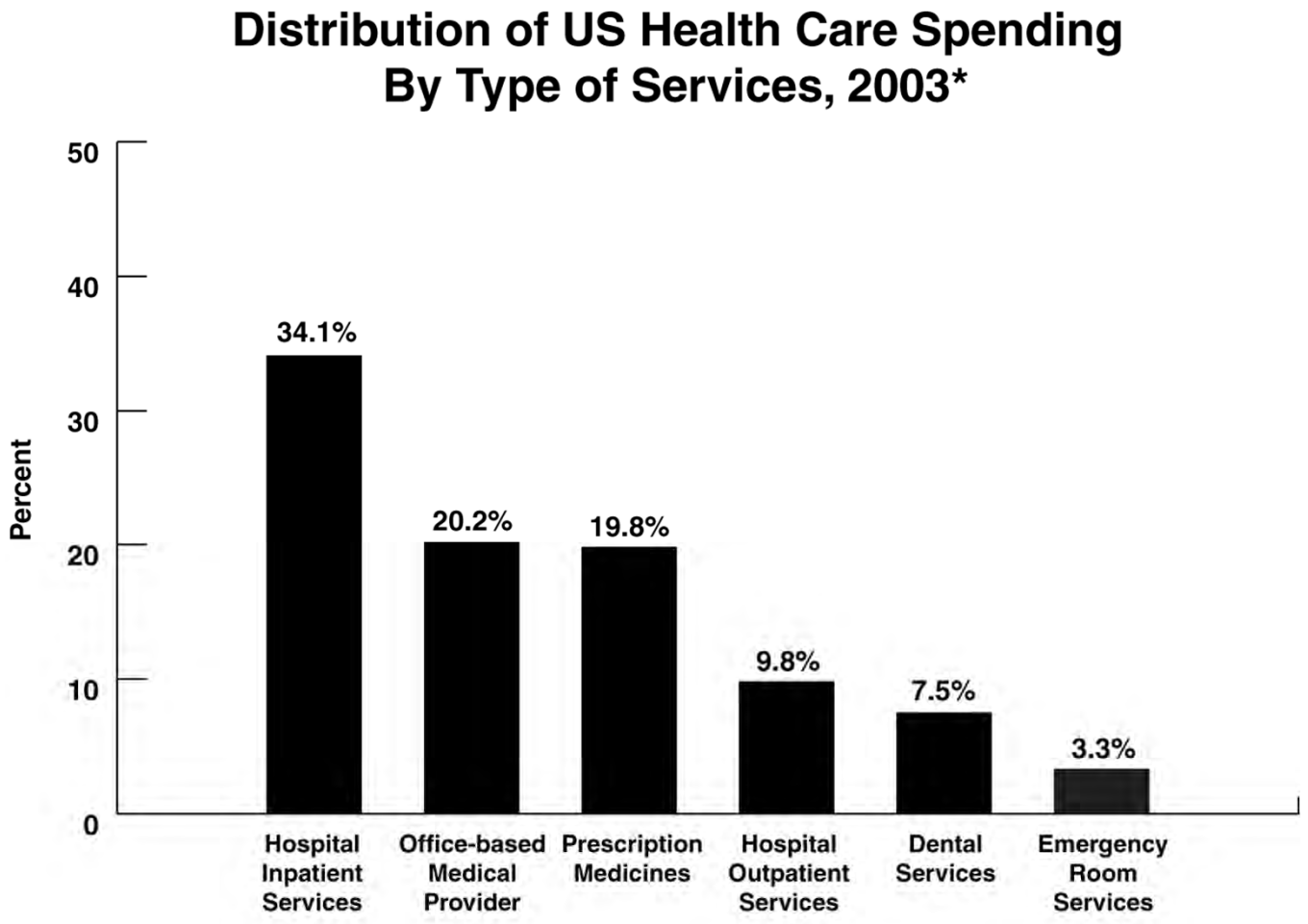
**If Not, Someone Else Will…**

**And Neither Providers nor Patients Will Like the Result.**

# At Least 30% of Health Care is for Duplicative, Unnecessary, or Poorly Delivered Services

- Four certain categories of unnecessary (sometimes harmful) spending in America
  - Inefficient hospitals
  - Poor management of chronic diseases
    - 30% of health care spending
  - Unnecessary or poorly evaluated procedures
    - ≥6% of hospital spending (estimate)
  - Emergency room over-usage

# Prime Direct and Indirect Spending is Similar to Overall US Health Care Spending




*Source: Center for Financing, Access, and Cost Trends, AHRQ, Household Component of the Medical Expenditure Panel Survey, 2003.*

**US Civilian Noninstitutionalized Population*

# MHS is Probably no Exception to Wasteful Spending.

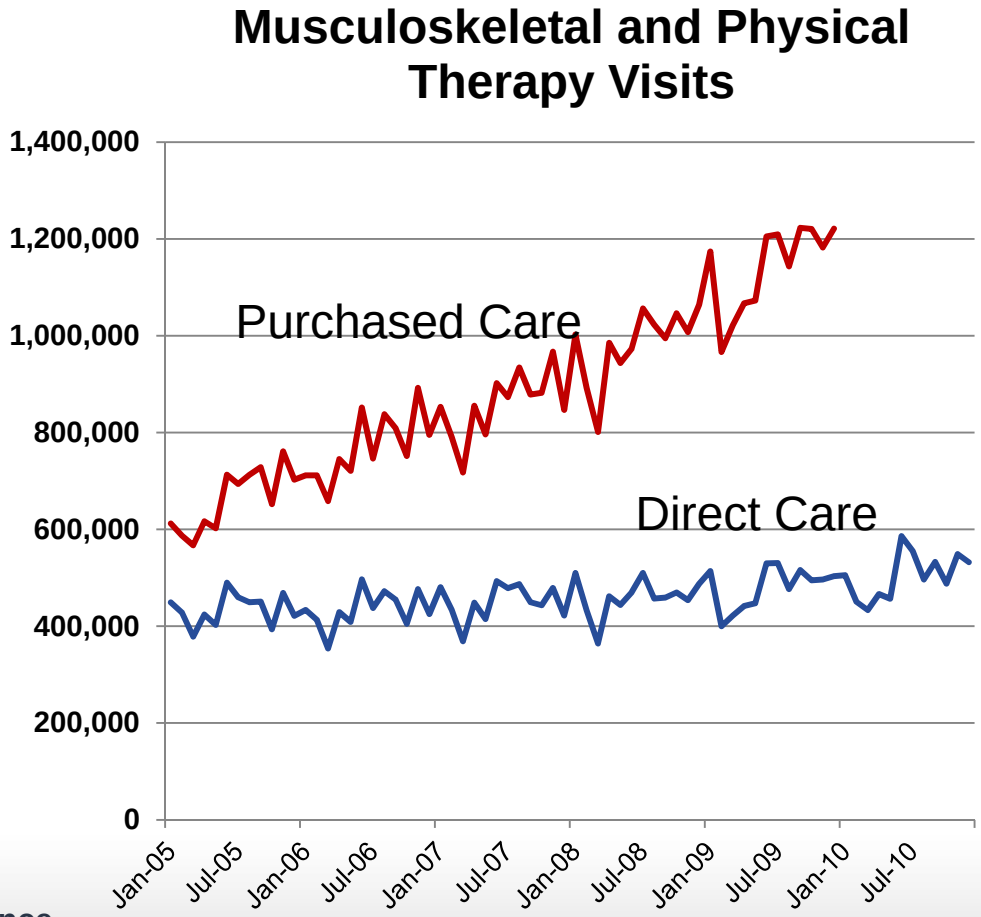
- Major categories of Probably or Certainly Unnecessary MHS Spending (percent of total?)
  - Musculoskeletal outpatient procedures and treatments
  - Emergency Room Over-usage
  - Pharmaceuticals

# Probable Overuse

## OUTPATIENT MUSCULOSKELETAL CARE

# Growth in Musculoskeletal Visits and Treatments

- Contractors routinely authorize 20+ visits per episode




*SOURCE: Dr. Bob Opsut, OSD (HA), 2010*

# Almost Certain Overuse

## EMERGENCY DEPARTMENT VISITS

# In the Bronx 80% of ER Visits Need Not Have Occurred

- New York City, 6 Bronx Hospitals, 1994/1999
  - Non emergent-41%
  - Emergent, primary care treatable-33.5%
  - Emergent, ED Care Needed, Preventable/Avoidable-7.3%
  - Emergent, ED Care Needed Not Preventable/Avoidable—17.9%

*SOURCE: Emergency Department Use in New York City: A Substitute for Primary Care? Billings J, Parikh K, and Mijanovich T, Commonwealth Fund Issue Brief, 2000*

# Most Common Reasons for ED Visit in MHS are Primary Care Treatable/Preventable.

- Most Common MHS Emergency Department Diagnoses based on Total Visits* ; Non-AD MTF Prime Enrollee
  - Acute Upper Respiratory Infections — 62,977
  - Unspecified Otitis Media — 52,272
  - Fever — 50,758
  - Chest Pain, Unspecified — 44,108
  - Acute Pharyngitis — 39,617
  - Urinary Tract Infection — 33,687
  - Headache – 33,050

**Total Visits based on DC encounters and TED visits for 2008*

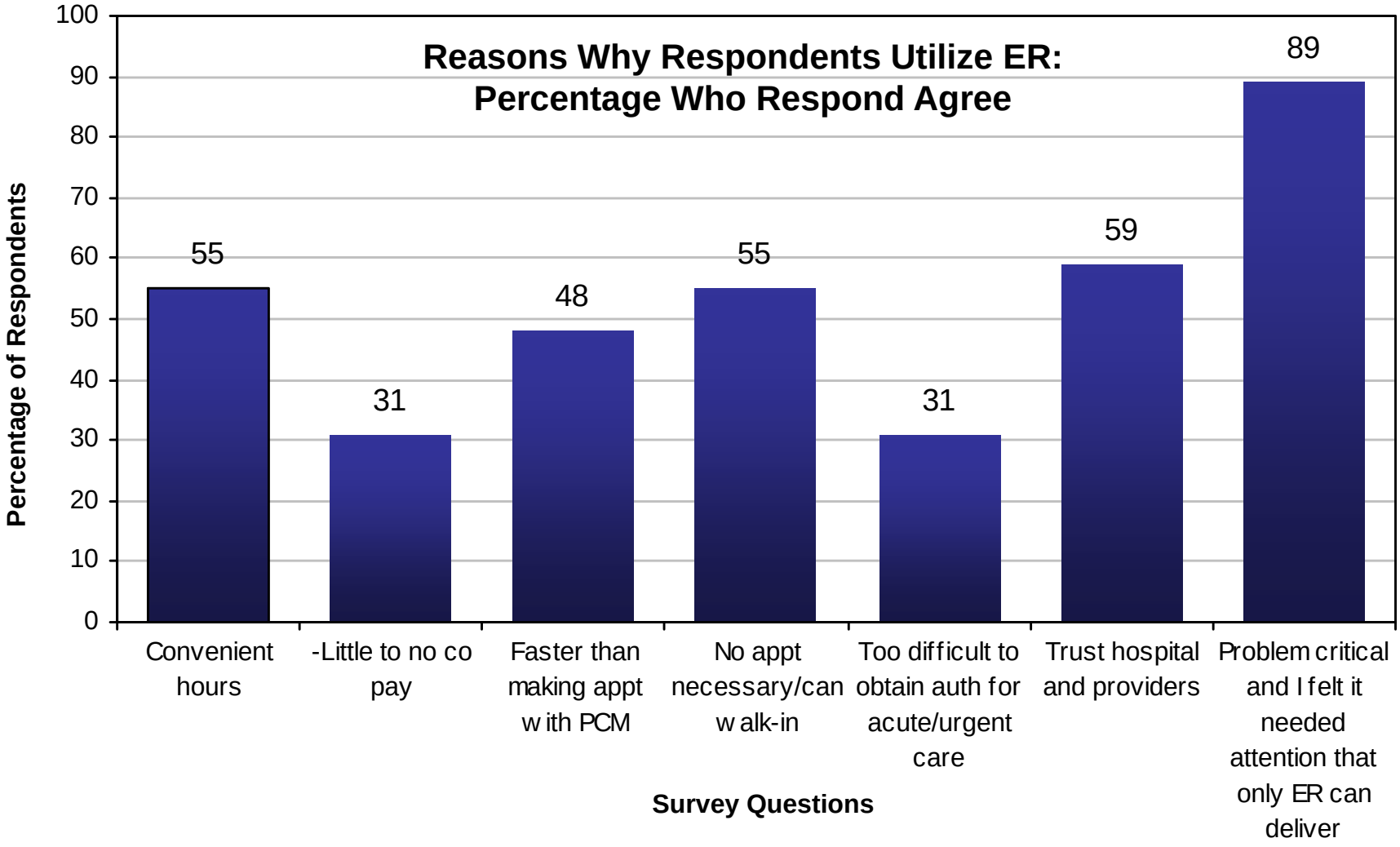
# MHS Beneficiary use of EDs is Double that of Privately Insured.

- Average Emergency Room Utilization Rates

| Type of Patient | Average Rate (per 1000, per year) |
|---|---|
| **Privately Insured Patients** | 210 |
| **Medicare Patients** | 480 |
| **Uninsured Patients** | 480 |
| **Western Region Military Health System (MHS) Patients** | 494 |

*SOURCE: TRICARE Management Activity (TMA) TRO-West ER Utilization Survey Results Final Report – Deloitte Consulting, 2009*

# Why did you go to the ED?






*SOURCE: TRICARE Management Activity (TMA)*
*TRO-West ER Utilization Survey Results Final Report – Deloitte Consulting, 2009*

# Future of TRICARE

**Accountability for cost and quality requires systems of care.**

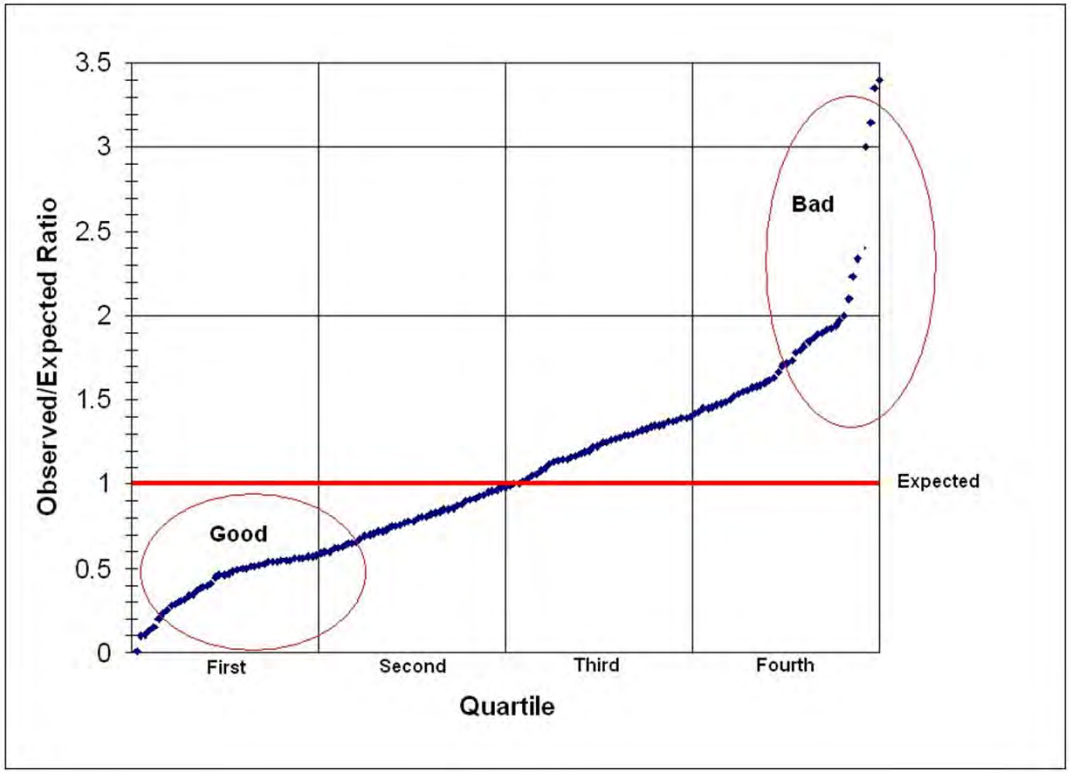
# Means of Creating Value

## Systems of care require clarity of purpose.

- Establish desired **Outcomes.**
- Align **Organization of Care and Provider Payments** with desired outcomes.

# An Example of Aligning Outcomes with Payment.

- Observed/Expected Post-Operative Pneumonia Rates




*Source: National Surgical Quality Improvement Program*

# A Huge Investment…

- Latter Day Saints Hospital (Salt Lake City) takes treatment of pneumonia to another level
  - Change in ICU culture
  - Collaborative protocol development
  - Monitoring of compliance
  - Reduced sedation and paralysis
  - Reduced blood glucose
  - Reduced intravenous feeding
  - Antibiotic protocol
  - Stress ulcer prophylaxis

# For Which the Hospital Was Penalized.

- And loses money doing it
  - Hospital-acquired pneumonia rate decreased from 12% to 3%
  - Substantial investment in best processes reduced their cost by $5000 per patient*
  - Turned it all over to payers

**SOURCE: Clemmer et al, Critical Care Medicine, Vol. 27 1999*

# Assumptions & Conclusions

- Policy makers will use price cutting to manage cost if providers do not…
- …which may result in access and quality problems for government-funded patients.
- If providers accept accountability for cost and quality they can forestall price cutting.
- Accountability for cost and quality requires systems of care
- Systems of care require clarity of purpose---benchmarks and aligned incentives.

# T4 Study Group's Initial Findings

## COL Brian Unwin

# Membership

| | |
|---|---|
| **Service Reps** | CAPT Lea Beilman (N) |
| | Col JoAnne McPherson (F)<br>LtCol Frederick Grantham (Alt) |
| | LTC Lori Howes (ARC) |
| | LTC Floreyce Palmer (A) |
| | LT Leah Mooney (CG) |

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| | Ms Jennifer Porter (TRO-W) |
| | Ms Paula Evans |
| | CDR Jamie Lindly |
| | Mr Drew Obermeyer |
| | Ms Barbara Zeliff |
| | Mr Rick Hart |
| | Ms Beth Spearman |

| | |
|---|---|
| **OSD-Cape** | Ms Carol Moore |
| | Mr Garrett Summers |

| | |
|---|---|
| **USUHS** | CDR Glen Diehl |
| | COL Brian Unwin |

# Core Principles

- Achieve the Quadruple Aim
  - Readiness and responsiveness
  - A healthy and fit population
  - A positive patient experience of care
  - Responsible management of the per capita cost of care

# T4 Study Group

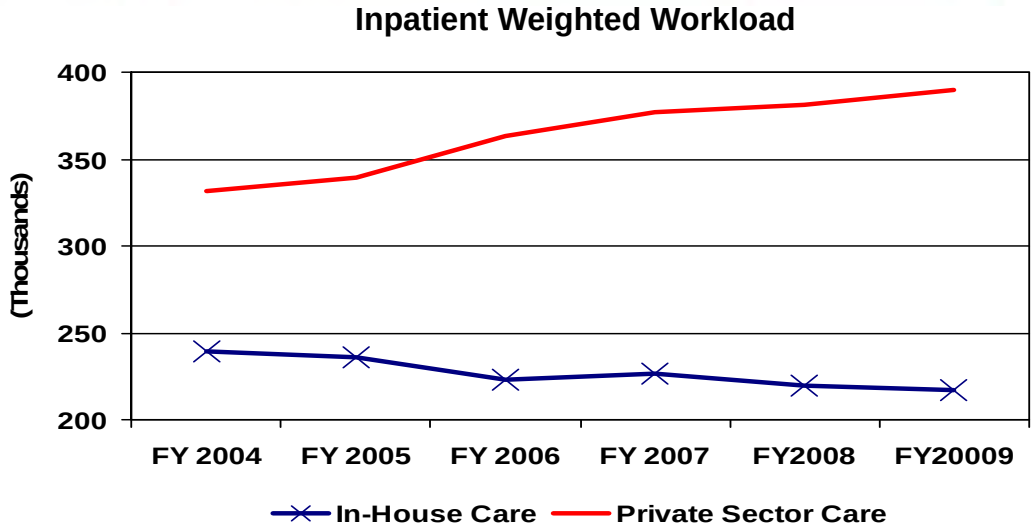
Which of These Five Options (among others we may discover ) will Create the Most Value and Preserve Readiness?

1. **Incremental change to the existing Direct/Purchased (Managed) Care Regional model**
2. **Federal Employees Health Benefit Program/Medicare**
3. **MTF-Centric Systems of Care**
4. **Purchased systems of care from integrated provider groups**
5. **Model 3 + 4**

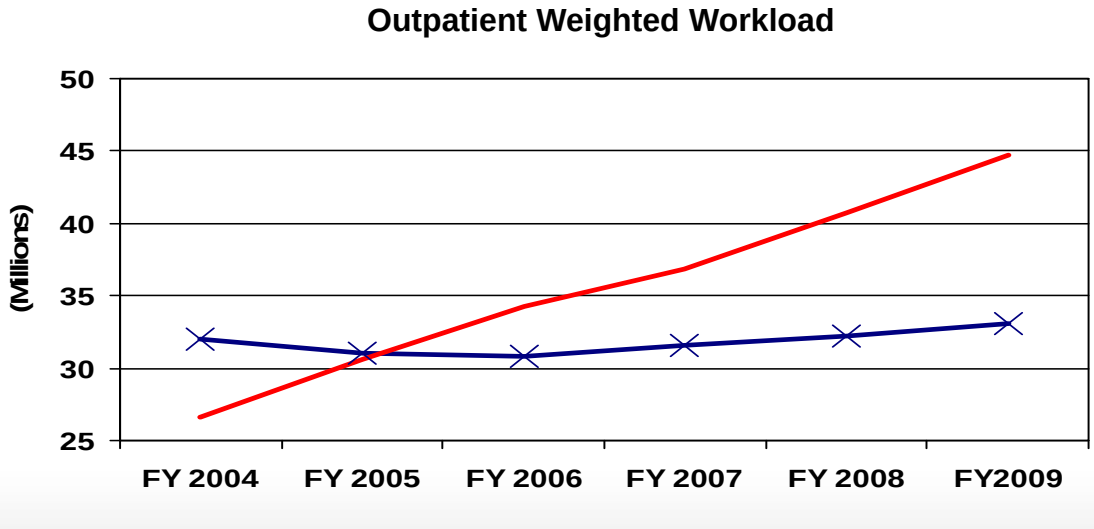
# The T4 Study Group's Focus is Purchased Care, But…

**Purchased care decisions will affect direct care.**

# Direct Care Shifts




*(Excludes MERHCF)*



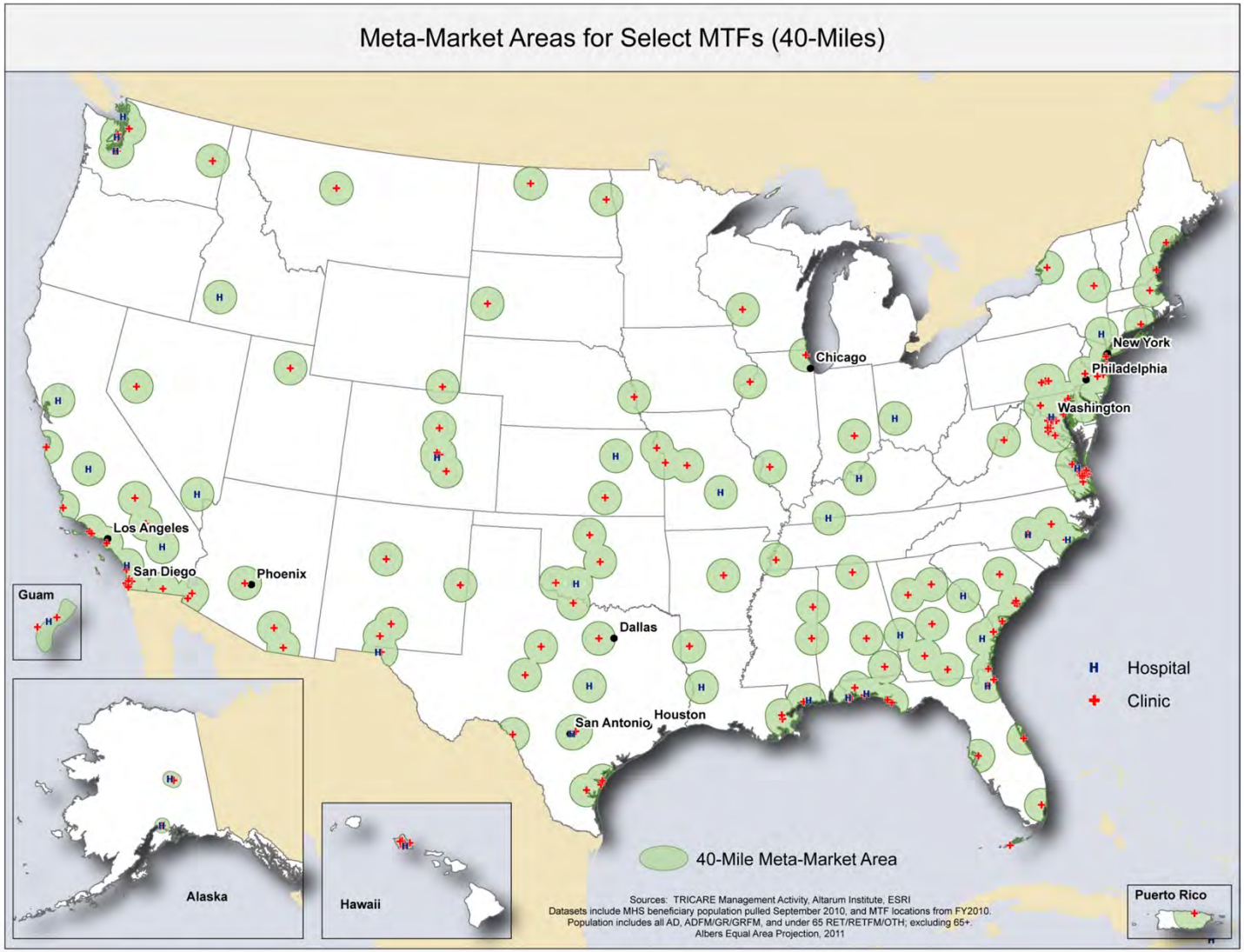

*(Excludes MERHCF)*

*SOURCE: Dr. Bob Opsut, OSD (HA), 2010*

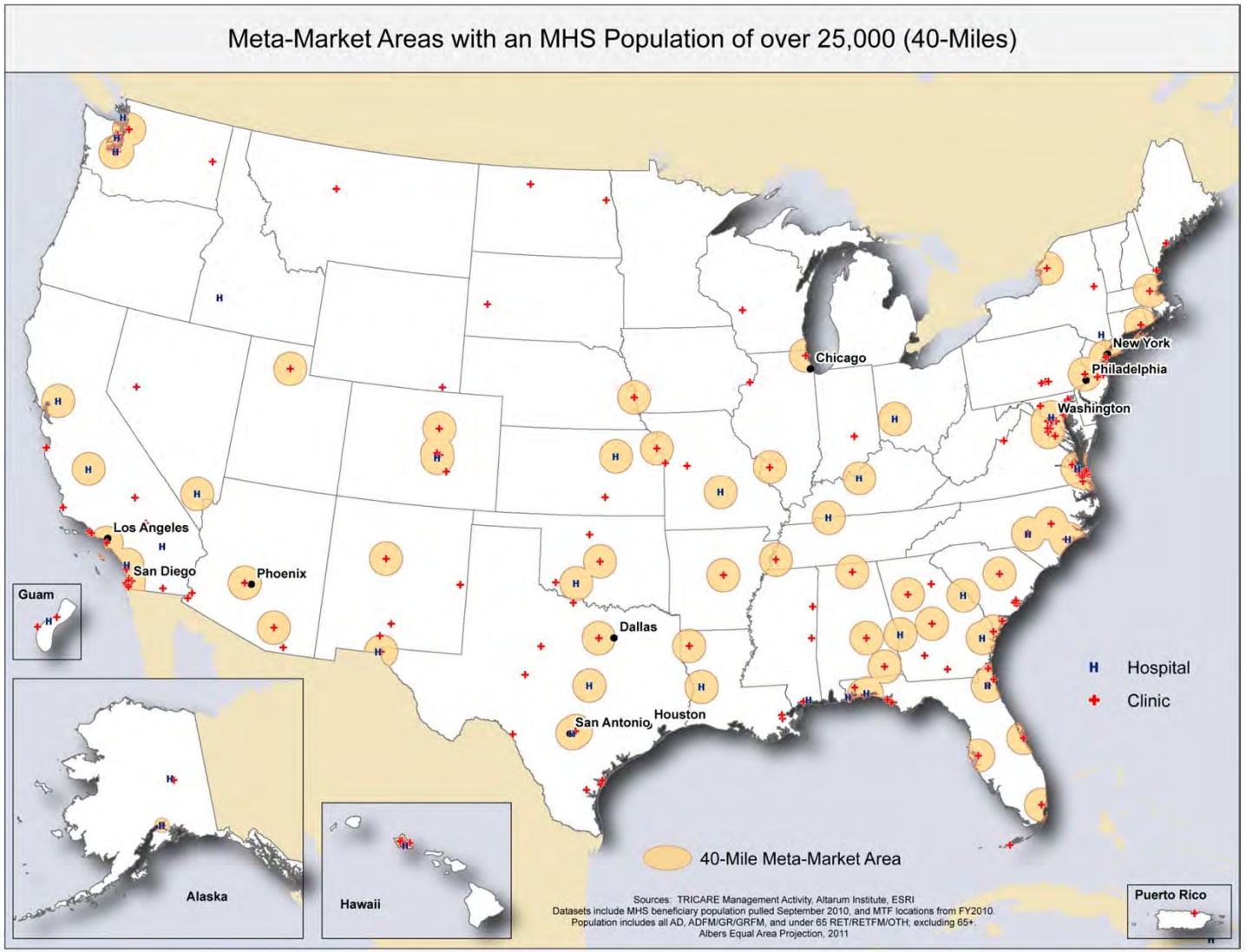
# MTFs and Their Catchment Areas Vary Widely

**One Size Will Not Fit All.**

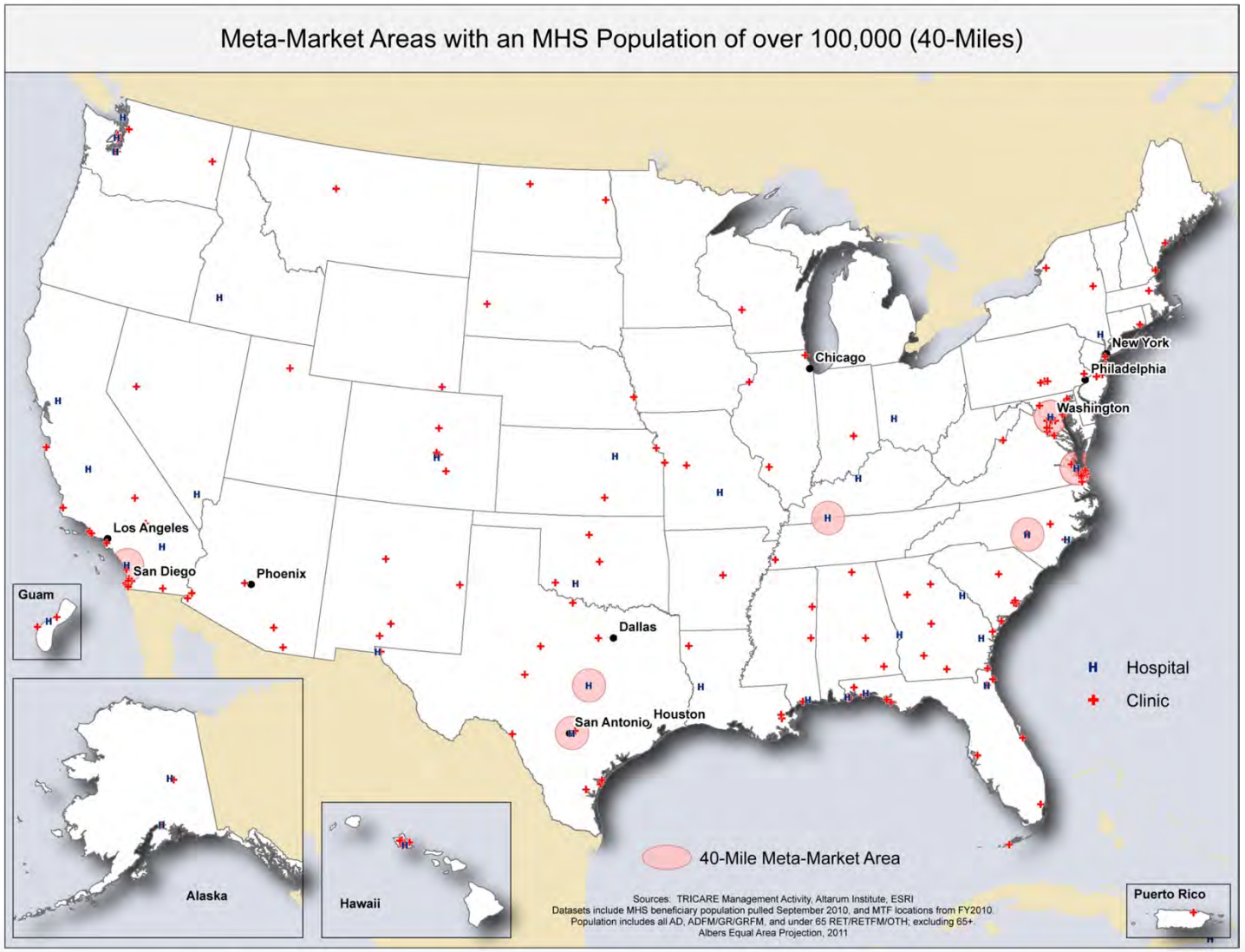
# MTF Market Areas



# MTF Market Areas



# MTF Market Areas



# Five Models

- TRICARE with incremental improvement
- FEHBP, Medicare
- MTF Centric Care
- Purchased care: Integrated Provider Groups
- MHS Preferred Systems of Care

# Criterion Evaluated

- Readiness
- Population health
- Patient centeredness
- Cost management
- Provider behavior incentives
- Patient behavior incentives

- Member ranking 1-10 for each domain

# Model 1: Incremental Improvements

**Concept**

Incremental improvement of TRICARE

**Actions**

- Reduce MCSC admin cost
- Preserves Readiness
- Enhance to support population health
- Acquire, manage, and adjust scope of contracts

**Outcomes**

- Tied to civilian cost growth and quality
- Cost controls (co-pays, other)
- No pop. health in purchased care
- PCMH in purchased care?
- Could use disease management, PCMH, and ACOs
- Beneficiaries "unattractive" because of low reimbursement

# Model 2: FEHBP and Medicare

**Concept**

- For NAD beneficiaries
- MCSC no longer support PRIME and Standard
- MTF Prime continues where possible

**Actions**

- Lower admin cost with Medicare (3% v. 9%)
- Govt. pays full premium

**Outcomes**

- Loss of MCSC network discounts
- Increased OOP costs for beneficiaries
- Negative impact on readiness & GME
- Same cost escalation as private sector
- No population health

# Model 3: MTF Centric Care

## Concept

- MTF CDR responsible for capitated budget
- Primary care and Population health emphasis
- Patient complexity aligned to provider skill

## Action

- MCSC: smallest number of best specialty care
- Care management and reporting to providers
- Right of 1st refusal If MTF meets quality metrics

## Outcomes

- Quality measures, data collection, report cards
- MHS controls: processes, costs, & outcomes
- Integration of population health
- 5-7 year transition from TRICARE

# Model 4: Integrated Provider Groups

**Concept**

Purchase care from groups that accept capitation

Integrates pop health, cost control and quality

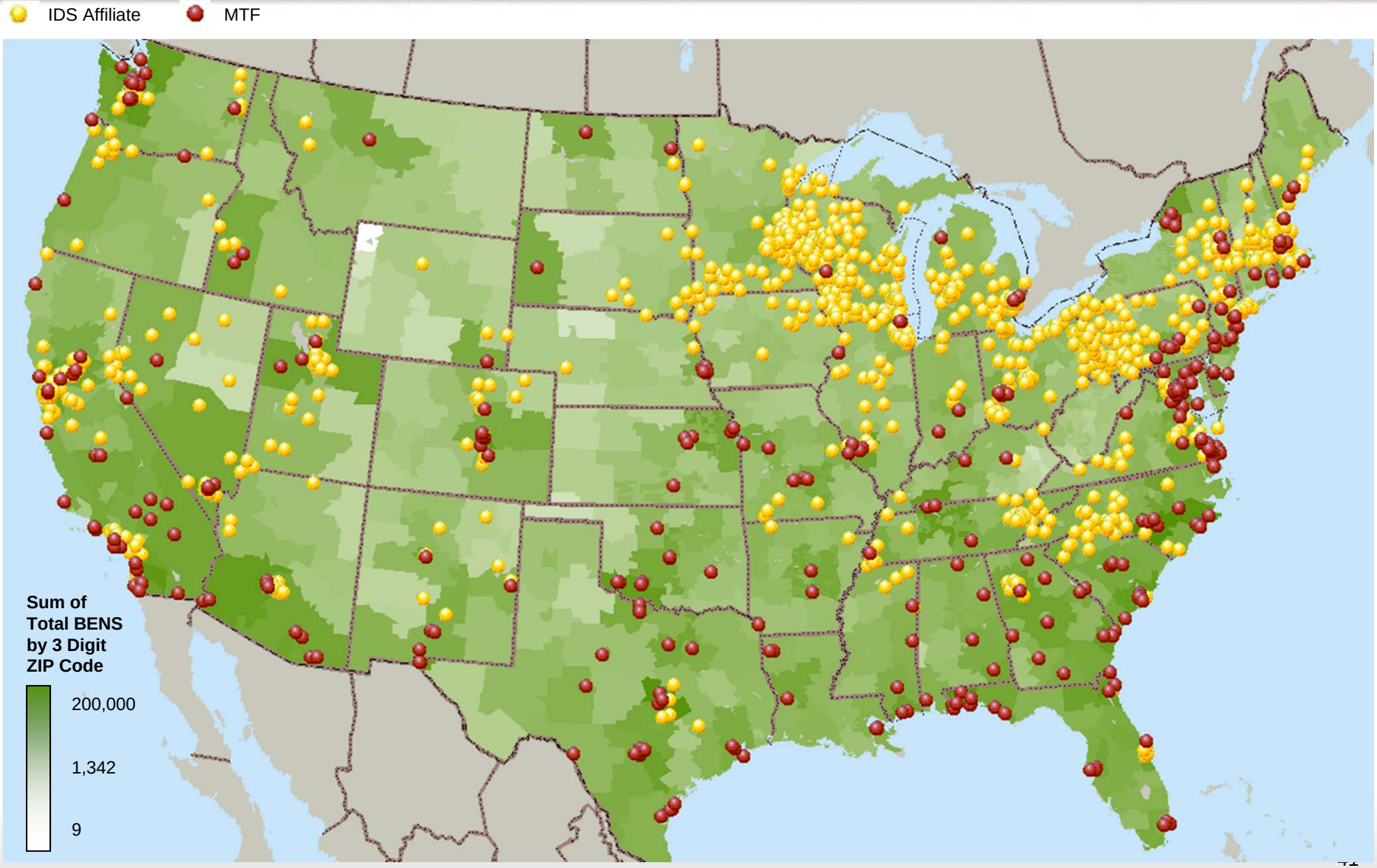
**Action**

| | | |
|---|---|---|
| Complex patient movement | Readiness impact? | GME Impact? |

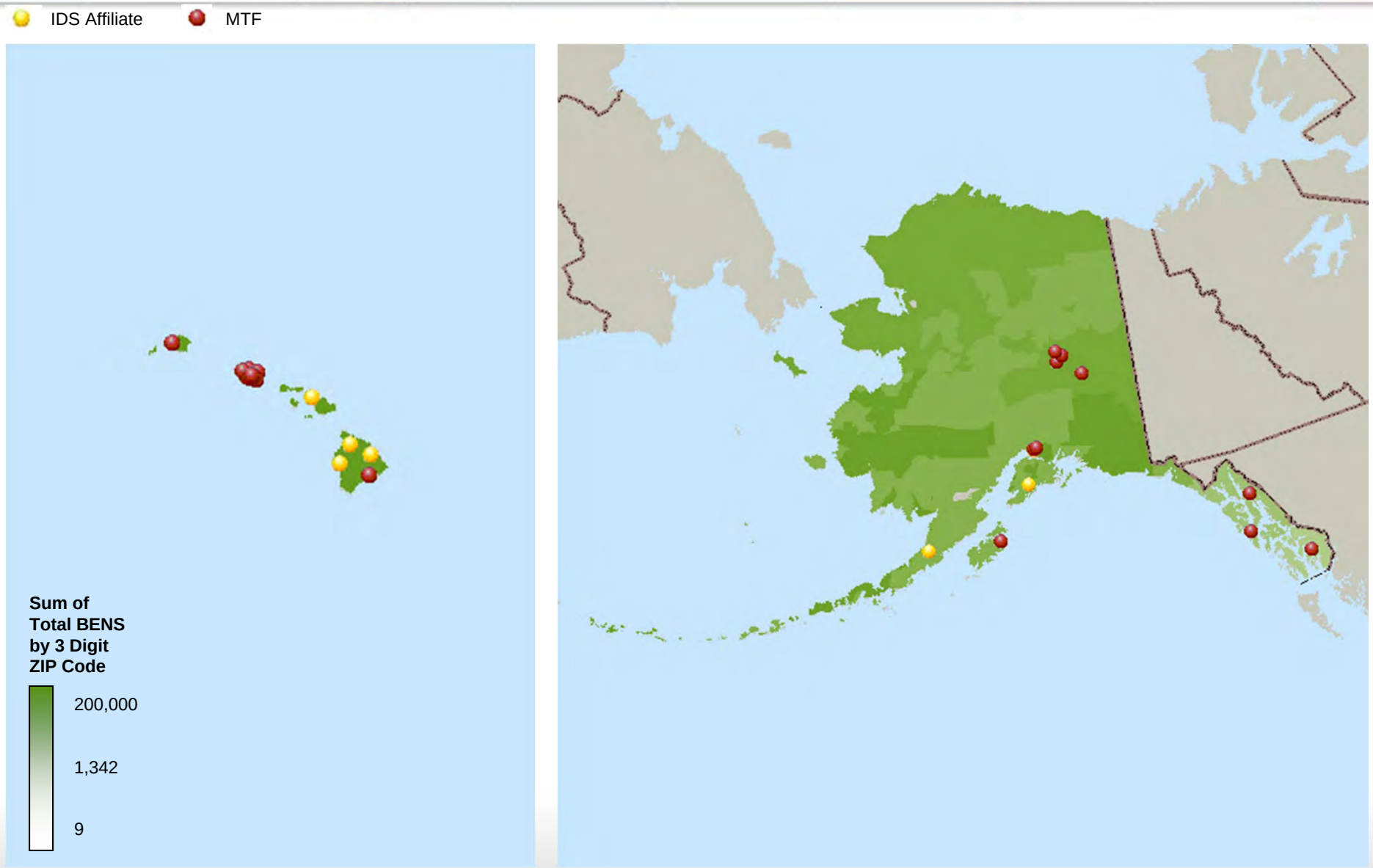
**Outcome**

| | |
|---|---|
| Cost savings? | Uncertain… |

# Overlap of TRICARE Beneficiary Population with Civilian Integrated Delivery Systems and MTFs



# Overlap of TRICARE Beneficiary Population with Civilian Integrated Delivery Systems and MTFs (HI + AK)



# Model 5: MHS Preferred Care

BKU1

- Combined 3&4
  - MTF Centric and Integrated Provider Groups

## Slide 43

**BKU1** How is this different from current TRICARE?
BRIAN K. UNWIN, 1/21/2011

# Criterion Scores by T4 Members

| Criterion | Option 1 Incremental TRICARE | Option 2 FEHBP & Medicare | Option 3 MTF Centric | Option 4 Purchase care from ACOs |
|---|---|---|---|---|
| Readiness | 7 | 3.8 | 7.3 | 5.3 |
| Pop. Health | 4.2 | 2.2 | 8 | 7.2 |
| Patient Centeredness | 4.9 | 3.9 | 7.3 | 7.8 |
| Cost Management | 3.9 | 3.8 | 6.3 | 7.7 |
| Provider behavior incentives | 5.3 | 3.3 | 7.3 | 7.6 |
| Patient behavior incentives | 3.6 | 4.1 | 7.1 | 6.9 |

# Timeline

- Kick-Off – October 2010
- Phase 1: Framing the Problem
- Phase 2: Scenario Development
- Phase 3: Detailed Analysis—outcomes, risks, consequences, feasibility

# Discussion

## Mr. Drew Obermeyer